STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. Building B. Wing	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Rock Springs, The	2530 North Monroe Street Decatur, IL 62526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on record review and interview the facility failed to ensure R3 and R6 were not subjected to physical abuse by another resident (R4, R11 respectively). This failure affected four residents (R3, R4, R6, R11) out of four residents reviewed for abuse in a sample list of eleven residents. Findings include: The facility policy titled 'Abuse, Neglect and Exploitation' revised 6/8/2020 documents the following: Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone including but not limited to: facility staff, other residents, consultants, contractors, volunteers or staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes, but not limited to, hitting, slapping, pinching and kicking. 1.) R3's Undated Face Sheet documents medical diagnoses of Alcoholic Cirrhosis of Liver without Ascites, Tremor Anxiety Disorder, Low Back Pain, Myocardial Infarction, Coronary Angioplasty Implant and Graft, and Cerebral Aneurysm. R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 6 out of 15 possible points indicating R3 is moderately cognitively impaired. This same MDS documents R3 requires extensive assistance of one person for transfers and locomotion on and off the unit. R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 15 out of 15 possible points indicating R4 has no cognitive impairment. This same MDS documents R4 requires supervision with walking and locomotion on the unit. R3's Nurse Progress Note dated 6/24/22 at 9:28 AM documents, (R3) was victim to physically aggressive contact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Final Incident Report to Illinois Department of Public Health (IDPH) dated 6/28/22 documents The witness (V25) stated (R3) was getting on the elevator and (R4) ran onto the elevator. (R3) tried to stop (R4) and (R4) hit (R3) in the shoulder numerous times. On 7/5/22 at 1:10 PM R3 stated (R3) was entering the elevator on the fourth floor when (R4) pushed her way in. I told (R4) she did not belong on the elevator and (R4) began punching me with (R4's) fist in the Left Shoulder. (R4) hit me hard several times in the shoulder. (R4) was hostile that day. (R4) was just out of control. I do not know why (R4) hit me, but I keep my distance from (R4) as much as possible. On 7/6/22 at 9:30 AM V25 AM Certified Nurse Aide (CNA) stated V25 heard a commotion from the elevator and ran around the corner to witness R4 hitting R3 in the Left Shoulder area. V25 stated V25 immediately stood in between R4 and R3 to prevent R3 from getting hit any further. V25 stated after placing V25's self between the two residents (R3, R4), R4 began punching and scratching V25. On 7/6/22 at 8:45 AM V1 stated the fourth floor of facility is considered semi-secure. V1 confirmed the elevator door could be opened by staff with key or by someone arriving to fourth floor. V1 stated R4 should not be allowed to get on elevator without supervision. V1 stated this altercation could have been prevented if staff were monitoring R4 more closely. 2.) R6's Undated Face Sheet documents medical diagnoses of Alzheimer's Disease, Dementia with Behavioral Disturbance, Dysphagia, Unsteady on Feet, Weakness, Fatigue and Seizures. R6's Minimum Data Set (MDS) dated [DATE] documents R6 is moderately cognitively impaired. This same MDS document R6 requires extensive assistance of one person for transfers and locomotion on the unit. This same MDS documents R6 is unsteady and requires staff assistance when moving from a sitting to standing position. R11's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 6 out of 15 possible points indicating moderate cognitive impairment. This same MDS documents R11 requires extensive assistance of one person for walking in room and locomotion on unit. This same MDS documents R11 has no impairment in functional limitation in Range of Motion for upper and lower extremities. R6's Nurse Progress Noted dated 6/19/22 at 2:50 PM documents Heard (R6) yell ouch. V31 (R10's) Power of Attorney (POA) informed staff that (R11) rammed walker into (R6) leg, and (R11) stated, 'I will kill you. You stole my stuff'. R6's Final Incident Report to Illinois Department of Public Health (IDPH) dated 6/23/22 documents V31 (R10's Power of Attorney) was in dining room when (the) incident occurred. V31 stated (R11) took walker and pushed into (R6's) legs, saying (R6) stole (R11) stuff. On 7/6/22 at 3:05 PM V3 Assistant Director of Nurses (ADON) stated V3 remembers the day that R11 'shoved' a walker into R6. V3 stated R6 was not injured but easily could have been. V3 stated there was another resident on that floor that day that was having behaviors and the staff were focused on the other resident. V3 stated no one was really watching R11 closely and that is how R11 got close enough to R6 to shove the walker into R6's legs. V3 stated R11 has hallucinations sometimes and thought R6 had stolen something from R11. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/7/22 at 9:30 AM V20 Physician stated Residents who are cognitively impaired rely on the staff to care for them. This includes monitoring to help prevent one resident abusing another resident. I realize they (staff) cannot be everywhere all the time but this facility does have a lot of reports of resident to resident abuse. I think if the staff were watching more closely this could have been prevented.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on record review, observation and interview the facility failed to follow their transfer policy and care plan interventions to ensure safe mechanical lift transfers for two of three residents (R1 and R2) reviewed for accidents in a sample list of eleven residents. These failures resulted in R1 suffering a fractured ankle when staff failed to utilize two staff members for a transfer and R2 suffering a laceration requiring sutures when staff failed to monitor and stabilize R2's legs during a transfer. Findings include: The facility policy titled 'Safe Resident Handling Transfers' implemented 7/21/21 document the following: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. Two staff members must be utilized when transferring residents with a mechanical lift. 1.) R1's Undated Face Sheet documents medical diagnoses of Closed Fracture of Distal Right Tibia, Closed Fracture of Distal Right Fibula and history of Non-Rheumatic Mitral Valve Insufficiency, Non-Rheumatic Aortic Valve Insufficiency, Atrial Fibrillation, Deep Vein Thrombosis (DVT), Left Hand Contracture, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non Dominant Side, Dementia Without Behavioral Disturbances and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired and requires extensive assistance of two people for bed mobility and dressing. This same MDS documents R1 requires total dependence of two people for transfers. R1's Care Plan intervention dated 10/26/21 instructs staff to assist R1 to maintain body in functional alignment when in mechanical lift sling and support lower extremities as necessary until R1 is placed on intended surface (bed, wheelchair, toilet). R1's Nurse Progress Note dated 6/29/22 at 12:47 PM documents Staff reported to writer that (R1's) right ankle appears swollen. R1's X-Ray Report dated 6/29/22 documents Impression: Fracture of the Distal Fibula at the juncture of the diaphysis and metaphysis. There is some displacement and angulation present. There is an additional Fracture of the Distal Tibia with slight cortical angulation but no significant displacement. On 7/5/22 at 12:35 PM V5 Licensed Practical Nurse (LPN) removed R1's blanket. R1's Right Ankle was much larger than R1's Left Ankle. R1's Right Ankle area was bruised over approximately half of Right Ankle area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/5/22 at 2:10 PM V4 (Family Member) stated there have been several times that a staff member will ask family to step out of R1's room to reposition R1 from bed to a wheelchair or from wheelchair to bed. V4 stated one staff member goes into the room, closes the door and then leaves the room and (R1) is in a different position. (R1) is supposed to have two staff help get (R1) up or lay (R1) down since (R1) uses a mechanical lift. I can tell you that does not happen. On 7/6/22 at 8:50 AM V19 Certified Nurse Aide (CNA) stated V19 first saw R1's right ankle injury on the morning of 6/29/22. V19 stated V19 remembers clearly because V19 had been on vacation and V19's first day back to work was 6/28/22. V19 stated R1 did not have any right ankle swelling or pain on 6/28/22. V19 stated V19 worked 6:00 AM-2:00 PM on 6/28/22. V19 stated V19 returned to work at 6:00 AM on 6/29/22 and noticed R1's Right Ankle was twice its normal size and R1 seemed to have more pain in that area. On 7/6/22 at 1:10 PM V26 Certified Nurse Aide (CNA) stated V26 transferred R1 from the wheelchair to the bed using a mechanical lift on the evening of 6/28/22. V26 stated V26 transferred R1 without another staff member present during the transfer. V26 stated during the transfer R1's lower Right Leg got caught on R1's wheelchair. V26 stated V26 stopped and repositioned R1's leg. V26 stated that is when R1's leg was hurt. V26 stated (staff) should always use two staff members when transferring with a mechanical lift but (I) just got in a hurry that evening. On 7/7/22 at 9:25 AM V20 Physician stated R1 has not been able to walk for several years. V20 stated R1 is completely dependent on the staff at the facility for all cares. V20 stated the staff should always use two staff members when transferring a resident with a mechanical lift or the resident has a higher risk of being injured. V20 confirmed R1's Distal Tibia and Distal Fibula fracture were both acute injuries. V20 stated the Tibia bone is a larger bone in a person's body and is difficult to fracture. V20 stated if the staff would be more careful this kind of thing would not happen. V20 stated, This is a real setback for (R1). The staff caused harm for this resident (R1) by not maintaining (R1) safety during the transfer. If the staff would have transferred (R1) safely, this might not have happened. 2.) R2's Undated Face Sheet documents medical diagnoses of Right Shin Laceration and history of Dementia Without Behavioral Disturbance, Hypertensive Heart Disease with Heart Failure, Generalized Epilepsy and Epileptic Syndromes, Type II Diabetes Mellitus, Abnormal Posture, Muscle Weakness and Altered Mental Status. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as having moderately impaired cognition and requiring extensive assistance of two people for bed mobility, dressing, eating, toileting and total dependence on two people for transfers. R2's Care Plan focus area dated 6/28/22 documents, Skin tear of the Right Lower Shin with four sutures related to extremely thin skin and is noted to move legs while in mechanical lift due to confusion (R2) is unable to be educated on not doing this. This same Care Plan instructs staff to use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. R2's Physician Order Sheet (POS) dated June 1-30, 2022 documents a Physician order for Eliquis (anticoagulant) 5 milligrams (mg) twice per day for Hypertensive Heart Disease with Heart Failure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Nurse Progress Note dated 6/26/22 at 2:17 PM documents (V12) Certified Nurse Aide (CNA) was getting ready to do care on (R2) after being transferred by mechanical lift with assist of two and noted (R2) open area to right shin. R2's Nurse Progress Noted dated 6/26/22 at 6:57 PM document received update from hospital on (R2), (R2) received sutures, x-ray showed nothing broken. R2's Hospital Record dated 6/26/22 documents Chief complaint: Laceration. Review of Systems: Five centimeter (cm) curvilinear laceration into subcutaneous tissue on the anterior surface of the Right Shin. This same Record documents R2 received five sutures to Right Shin Laceration. R2's Final Incident Report to Illinois Department of Public Health (IDPH) dated 6/29/22 documents Disposition: Care Plan reveals (R2) requires a mechanical lift for transfers and has an extensive history of skin tears during care due to frail skin turgor. The injury is consistent with placement of where the mechanical lift most likely caused the injury, and that (V12) Certified Nurse Aide (CNA) did not stabilize (R2's) body during the transfer. On 7/5/22 at 1:30 PM V17 Licensed Practical Nurse (LPN) removed an undated dressing from R2's Right Shin. A two-inch half moon shaped laceration with five sutures was present on R2's right shin. R2 also had a golf ball sized dark purple area just below the sutures with pink intact skin separating the two areas. On 7/6/22 at 3:10 PM V3 Assistant Director of Nurses (ADON) stated R2's laceration was first noted on 6/26/22. V3 ADON stated R2 has extremely fragile skin which tears and bruises easily. V3 stated R2 is also on an anticoagulant which causes bruising to be more severe. V3 ADON stated V12 Certified Nurse Aide (CNA) accidentally caused the laceration while transferring R2 from wheelchair to bed using a mechanical lift. On 7/6/22 at 3:50 PM V12 Certified Nurse Aide (CNA) stated, V28 CNA and V12 both assisted R2 to get out of the bed with a mechanical lift on the morning of 6/26/22. V12 stated there were no marks on R2's lower legs when getting R2 out of bed in the morning. V12 stated V28 helped transfer R2 from the wheelchair back to bed that same afternoon using the mechanical lift. V12 stated after transferring R2 to the bed, V12 was attempting to remove R2's pants to provide incontinence care when V12 noticed R2 had a laceration to the Right Shin. V12 stated it looked fresh. There was not much blood, but I could see red flesh in the wound. V12 stated R2 has very thin skin that tears easily. V12 stated I must have hit (R2's) leg on the mechanical lift because the wound was fresh, and it wasn't there earlier. It couldn't have been from the sling because that was too high up. It had to have hit against the machine. On 7/7/22 at 9:29 AM V20 Physician stated R2 is known to have very fragile skin which tears easily. V20 stated R2 has been on anti-coagulant long term therapy which can sometimes cause the tissue to be more delicate. V20 stated Even if there were two staff member transferring (R2) the staff still need to be careful with someone like (R2) who is so prone to skin injuries. In this case, (R2) was harmed by the staff and received several sutures due to the staff not properly transferring (R2). If the staff were watching (R2's) legs, this would not have happened.